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ILLINOIS ACADEMY OF FAMILY PHYSICIANS

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Asim Jaffer, MD – Board of Directors
Illinois Academy of Family Physicians
Testimony before the Illinois Health Care Reform Implementation Task Force
October 5, 2010 - Peoria, Illinois

Good afternoon and thank you for the opportunity to provide comments to the task force about the challenges and opportunities we face as a state in this new future of health care reform.

My name is Dr. Asim Jaffer, and I am a faculty family physician at the University of Illinois Methodist Medical Center family medicine residency program in Peoria. I am also a member of the Illinois Academy of Family Physicians Board of Directors.

I was asked to provide insight on these topics:

1. Supply and demand of health care workers across the state
2. Scope of practice
3. Payment/reimbursement of providers
4. Re-education and re-training of current workforce with electronic health records.

Let me start with #2 – Scope of practice, because that's the easiest one to answer. Family physicians do it all in providing health care services in our state. Family doctors provide pre-natal care, deliver babies, treat children and care for adults through the end of life. We help keep people well and help them get better when they are sick. No other specialty has a broader scope of expertise.
Family physicians treat people, not parts. And each person is treated as a member of a family, a workforce and a community.

Supply and demand of health care workers across the state

The supply and demand forecasts for primary care physicians currently paint a daunting picture. The U.S. Census report estimates a 36 percent increase in Americans over age 65 that will be on Medicare by the year 2025. Typically the Medicare population comes to us with poor health care status and greater need for services. Many have multiple chronic conditions, requiring many medications, procedures and providers.

At the same time, the Association of American Medical Colleges (AAMC) projects a physician shortfall of more than 130,000 physicians nationwide by 2025. Our national organization, the American Academy of Family Physicians projects that Illinois will need an additional 1,000 family physicians more than our current level to meet demands for services that we will see by the year 2020. **Basically we need to ramp up family physician production by 30 percent.**

The numbers in Illinois are not even close. Illinois has eight medical schools throughout the state. This year, only 89 out of 1,184 - only 8 percent - of Illinois allopathic medical graduates chose family medicine… continuing a poor trend dating back to the mid 1990s.

-MORE-

We are already near the end of the year 2010. Today's first-year medical student could be a practicing family physician by 2017. So if we hope to shore up our supply of family physicians in 2020, we need to start moving those numbers up now.

The AAFP recommends the following to build the rural primary care workforce:
_ That medical education include curriculum and student experiences pertinent to careers in rural medicine.

_ That graduate medical education funding be redesigned to give direct and increased support to rural-based residency training programs, including teaching health centers.

_The AAFP supports partnerships between academic medical centers and rural communities to train rural physicians. These partnerships should be encouraged by financial incentives on the state and federal level.

_The AAFP recognizes that increasing the family physician supply will increase the rural physician supply, since family physicians are more likely than any others to enter rural practice.

Medical students need exposure to primary care in community settings. Illinois just completed a year of the SEARCH program, where the Illinois Primary Health Care Association places health professions students and medical residents in elective rotations at community health centers throughout the state, including the Heartland centers here in the Peoria area. These programs can be instrumental in bringing more professionals into the primary care workforce and into community health centers and other underserved settings. This program needs to be supported and continued.

There are some elements in the health care reform package that will help primary care physicians. There are boosts in programs to provide loan repayment and forgiveness for primary care physicians who work in underserved areas.
There are provisions to increase the number of residency slots in primary care and the opportunities for residency programs to train physicians in the community and not in the hospital.

Payment/Reimbursement

As much as personal mentors and positive experiences can shape a student's decision to pursue primary care and practice in underserved areas, without question money talks. In our current health care system, primary care compensation lags far behind our subspecialty counterparts. A recent report from the Robert Graham Center in Washington, DC compares the annual median income of internal medicine and family medicine physicians against the median compensation for orthopedic surgeons and radiologists.

Since 1981, the median compensation for the two subspecialties has grown from about $100,000 to $400,000. Meanwhile the family physicians and internists have seen their annual income flatten out over the past ten years hovering just over $150,000. As a result, the primary care physician is paid nearly **a quarter of a million dollars LESS per YEAR** than a radiologist. Considering that medical school debt is the same regardless of your specialty, it's easy to see how a student would choose a subspecialty over primary care.

The Council on Graduate Medical Education (COGME) provides ongoing assessment of physician workforce trends and makes recommendations to the U.S. Secretary of Health and Human Services and committees of Congress. Dr. Russell Robertson, chair of the family medicine department at Northwestern University – Feinberg School of Medicine in Chicago chairs this council. In a May 2009 letter, COGME outlined many ways the U.S. can boost the primary care physician workforce.
Correcting the income disparity between primary care and subspecialty physicians is one of their recommendations. COGME's analysis concludes that boosting primary care incomes to at least **60 percent** of the equivalent subspecialty income would turn the tide back toward primary care.

Federal health care reform provides for some temporary increases in Medicare payment favorable to primary care. The federal reform bill also requires state Medicaid programs to match Medicare payment rates for physician services in 2013 and 2014. The federal government will provide the funds for states to make those increased payments. However there is no federal money for those increased Medicaid rates after 2014. It's critical that Illinois continue those higher rates for the providers who care for the millions of Medicaid patients in our state.

The public payers must set the standard in better payment models for primary care so that private payers can follow this lead. We have found very few private payers are willing to lead in moving our system toward one that pays for preventive care, coordination and quality rather than the current system that rewards procedures and perpetuates the income imbalance we see today.

Workforce goals will NOT be realized without payment reform.

Illinois is on the right track with Medicaid's medical homes, built through the Illinois Health Connect program. Along with the disease management program, Your Healthcare Plus, these two programs show promise in providing better care and lowering overall health care costs by preventing unnecessary emergency room visits and hospitalizations.

Both of these programs are powered by primary care physicians and provide patients with a medical home, a first point of care and a physician who knows them. Illinois Health Connect provides increased payments to primary care physicians for coordinating their patients' care beyond the office visit, and for exceeding quality measures. In essence, they pay for the good work that primary care providers have always done, but have not been paid for in the traditional system.

These programs work and are essential to achieving long-term cost-savings in the Medicaid and state health plans. Their success shouldn't be kept secret, but rather should be shared, duplicated and expanded.

And finally, Illinois must address the unstable medical liability climate in our state. Due to the Illinois Supreme Court's decision to strike down the Medical Liability Law from 2005, Illinois once again becomes a daunting place to practice. Physicians may choose another state over Illinois, where premiums are lower and the court system is fair to patients and providers.

Re-education and re-training of current workforce with electronic health records

-IAFP has long advocated for electronic medical records. We helped pass legislation creating the EHR Task Force. Currently, IAFP is involved with and supporting the upcoming Illinois Health Information Exchange. Family medicine is poised to lead in this transition. We know it's essential to providing better, efficient care and reducing errors.

Tomorrow's physicians will grow up using computers and electronic health records. As an Academy, we are committed to helping all practicing family physicians make the challenging but necessary transition with the support of the state's regional extension centers.

We have made a lot of progress in many areas of health care in Illinois. IAFP and family physicians are ready to move full speed ahead in health care reform. We ask that the state follow these recommendations to support today's family physicians in our common mission to recruit and train more high-quality family physicians, providing the best possible care to all patients… of all ages… in every part of the state.

I thank you again for the opportunity to speak and welcome any questions you have.

-END-

For more information, contact Gordana Krkic, Deputy Executive Vice President, at gkrkic@iafp.com or 630-427-8007

ILLINOIS ACADEMY OF FAMILY PHYSICIANS

Contact: Ginnie Flynn, Vice President of Communications
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March 24, 2010

ILLINOIS FAMILY MEDICINE 2010 MATCH RESULTS

Match results for Illinois family medicine brought continued mixed news for our residency programs. According to NRMP, Illinois Family Medicine Residency Programs filled 88.7 percent (134/151) of available positions, which was the second-highest fill rate for the East North Central region, behind Indiana. However, our region fared worst among the nation's nine regions with the lowest fill rate of 83.4 percent (401/481). Illinois offered more positions this year (151 compared to 137 in 2009), which contributed to the lower NRMP rate. However, individual conversations with Illinois family medicine residency program directors reveal that many programs also signed residents outside the NRMP process and have filled their positions as of this writing.

Preliminary information available on Match Day from the 2010 National Resident Matching Program (NRMP) indicates that for U.S. family medicine residency programs 2,404 positions filled out of 2,630 positions offered (91.4%). One hundred one more U.S. seniors (1,184 vs. 1,083) chose family medicine in 2010 compared with 2009. More U.S. seniors participated in NRMP in 2010 compared with 2009 (16,070 vs. 15,638), with a resulting slight increase (7.9% vs. 7.4%) in the **percentage of U.S. seniors who chose family medicine**.

Link to results, charts and analysis at the AAFP web site's Match section at
http://www.aafp.org/online/en/home/residents/match.html

Residency program results by region and state:
http://www.aafp.org/online/en/home/residents/match/fillrate.html

Medical School graduates show some up and downs.
It was a mixed bag for Illinois medical schools in the 2010 Match. A slight increase of U.S. medical school graduates chose family medicine (7.9% up from 7.4% in 2009) and the overall percentage of Illinois medical students matching into family medicine a similar 8.0 percent, up from 2009's dismal 6.6 percent. Some Chicago medical schools showed increases in the number of family medicine graduates, while some of the other schools had fewer than average this year. The net result was a nearly one and a half percent increase in the percentage of Illinois medical school graduates choosing family medicine from 2009.

Percentage of Illinois graduates who chose FM residencies

YEAR	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
TOTALS:	**10.8%**	**10.4%**	**8.6%**	**6.5%**	**6.8%**	**7.8%**	**8.2%**	**7.5%**	**6.6%**	**8.0%**

See accompanying chart for individual school match rates

2010 Match Results for Illinois Medical Schools

Data obtained from web sites and e-mails to schools

Last updated – March 31, 2010

Medical School	# choosing FM (IL programs)	Total number of graduates	%
Rosalind Franklin – Chicago Med School*	7 (2)	185	3.8
Loyola Stritch School of Medicine*	12 (5)	116	10.3
Northwestern Univ. Medical School	8 (3)	157	5.1
Rush Medical College	8 (3)	135	5.9
SIU School of Medicine	8 (1)	64	12.5
University of Chicago – Pritzker	12 (3)	114	10.5
University of Illinois campuses			
Chicago	22 (13)	214	10.3
Peoria	5 (0)	52	10
Rockford	7 (2)	52	13.5
Urbana	0	27	0
U of I campuses combined	34 (15)	345	9.9
2010 Illinois Schools Total	**89 (32)**	**1116**	**8.0**
2009 Illinois Schools	*74 (27)*	*1,124*	*6.6*
2010 US Seniors totals	*1,184*	*16,070*	*7.9*

ROBERT GRAHAM CENTER

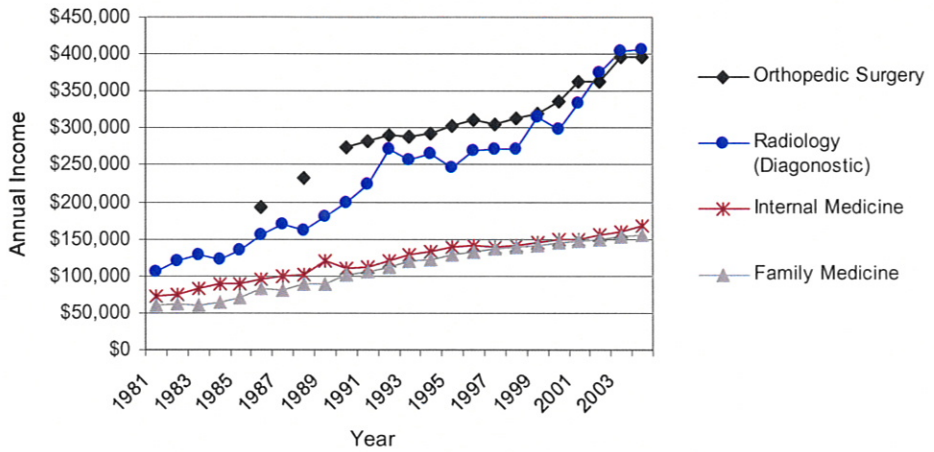
Income Disparities Shape Medical Student Specialty Choice

GRAHAM CENTER ONE-PAGER #67

Currently, a gap of more than $135,000 separates the median annual subspecialist income from that of a primary care physician, yielding a $3.5 million difference in expected income over a lifetime. These income disparities dissuade medical students from selecting primary care and should be addressed to ensure sufficient patient access to primary care.

The income gap between primary care physicians and subspecialists has grown steadily since 1979.[1] At the extreme, nearly $250,000 separated the median annual income of primary care physicians from the incomes of physicians in diagnostic radiology and orthopedic surgery in 2004 (see accompanying figure).[1] Over the past 30 years, the growth of this income gap reduced the odds of medical students choosing primary care or family medicine by nearly one half. It also reduced the odds of students working in a federally qualified health center or rural health center by 30 percent, and of practicing in a rural area by almost 20 percent.[1]

Figure: Comparison of annual income (median compensation) by physician subspecialty.[2]



The resulting difference in expected income over the average physician career is impressive. Data from the Department of Labor Statistics and the Medical Group Management Association show that primary care physicians earn a cumulative average lifetime net income of nearly $6.5 million compared with more than $10 million for subspecialists.[1]

Medical students who select non–primary care specialties stand to reap considerable financial benefits over those who choose primary care, despite the limited additional training time and expense involved in subspecializing. Even students who select business, law, and dentistry—careers with lower opportunity costs than medicine—can also expect greater relative financial rewards; the lifetime return on investment for each was greater than for primary care in the 1990s, and likely remains as such.[3] Policies reversing the growth of payment disparities could attract more students to primary care and secure access to an adequate primary care workforce.

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2. Adapted with permission from Phillips RL Jr, et al.; Robert Graham Center. Specialty and geographic distribution of the physician workforce: what influences medical student and resident choices? March 2009. http://www.graham-center.org/online/graham/home/publications/monographs-books/2009/rgcmo-specialty-geographic.html. Accessed January 4, 2010.
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Robert L Phillips, Jr., MD, MSPH
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Jerald M. Katzoff
Executive Secretary

COGME
Council on Graduate Medical Education

May 5, 2009

TO: The Honorable Kathleen Sebelius - Secretary of Health and Human Services
Dr. Mary Wakefield: Administrator – Health Resources Service Administration
The Senate Health, Education, Labor and Pensions Committee
The House Energy and Commerce Committee and its Health Subcommittee
The Medicare Payment Advisory Commission (MedPAC)
The Senate Finance Committee
The House Ways & Means Committee

FROM: The Council on Graduate Medical Education (COGME)

As the nation seeks to improve its health care delivery, the crisis in primary care looms as a major obstacle to achieving this goal. This challenge has been previously described by our committee and acknowledged by leaders of Congress. In that light, the members of COGME would like to share its key recommendations that relate to these critical issues in light of pending legislation on health care reform. These recommendations are based on the recognition that the re-invigoration of primary care is the basis for meaningful health care reform, and requires strategic investments to support primary care funding and training.

The primary care physician workforce (family medicine, general internal medicine and pediatrics) currently comprises 35% of all practicing physicians and is rapidly declining. Recent studies indicate that fewer that 20% of all US medical students are choosing primary care specialties. Congress, as part of health care reform, should modernize GME funding under Medicare and Medicaid to align financial and educational incentives to produce more primary care physicians capable of practicing in patient-centered medical homes in order to serve the growing need of Americans. This would help to satisfy a growing need for first-line and coordinated health and would begin to remedy the changes of the last 10 years where nearly all GME expansion in teaching hospitals has been in subspecialty medicine, often to the detriment of primary care.

Medical students are turning away from primary care for three reasons: poor income relative to other specialties; few primary care role models during their exposure to clinical medicine; and the high, unfunded administrative burden required to care for complex patients. Realignment of training priorities is now urgently needed to achieve true universal access to comprehensive, longitudinal healthcare for all Americans. To accomplish this goal, The Council on Graduate Medical Education recommends the following statutory changes:

Provide incentives and remove statutory barriers to the establishment and expansion of training venues in non-hospital primary care settings, including rural and underserved settings. Our current training infrastructure and funding will not produce enough physicians to meet the future needs in these venues. There is currently an imbalance in the sites of training that does not allow adequate preparation of a physician workforce for either the place where most healthcare takes place (outpatient settings), or for the medically vulnerable populations who need care the most (those in rural and underserved areas).

Mandate accountability for GME funding in order to reshape the incentives for teaching hospitals and academic medical centers to improve the health of the nation. The nearly $10 billion spent annually on GME (Medicare and Medicaid) is neither monitored nor regulated by the Federal government. Instead, the GME program portfolio is largely driven by the workforce needs of teaching hospitals. Current GME trends are not consistent with developing a more cost effective primary care-based health care system.

Permanently correct the income disparity between primary care and subspecialty physicians. The growing income gap between most subspecialties and primary care is a potent driver of student career choice, for hospital training priorities, and for poor delivery of preventive and coordinated care. GME reforms are necessary, but will be much more effective if combined with reduction of income disparities. Recent data presented at COGME notes that if primary care incomes were to reach a minimum of 60% of the incomes for specialists, current trends away from primary care could be reversed.

Make Graduate Medical Education sites laboratories for innovations in primary care delivery and responsible for producing the next generation of physicians who will work in them. Clinical teaching programs should yield practice innovations that lead to more cost-effective care. They should also prepare new physicians to develop, manage and operate "medical homes" ideally functioning in interprofessional teams with an assortment of providers. In this way, Medicare's investment in primary care training leads to an improved model of care and the workforce necessary to deliver it.

Provide financial support for primary care physicians to establish the infrastructure to coordinate patient care and reduce their administrative burden. Focusing on prevention and early intervention especially for chronic disease has been proven to reduce costs and improve outcomes. However, the current payment system does not reimburse primary care physicians for such care, which has been termed "the medical home".

We appreciate this opportunity to provide advice to the Secretary and key Congressional committees involved in health care reform. We have attached a document of background information and support for these recommendations. In addition, we would like the opportunity to meet with Senators Kennedy and Enzi, and Representatives Waxman, Barton, and Deal, regarding our recommendations. We will follow up with their schedulers to set up appointments.

Sincerely,

Russell G. Robertson MD
Chair
Council on Graduate Medical Education

Robert Phillips MD MPH
Vice Chair
Council on Graduate Medical Education

This attachment is an update from COGME regarding recommendations made in its 16th and 19th reports and an analysis of recent evidence of how medical education expansion is occurring.

Comments from Key Leaders:

"[W]e have a shortage of primary care providers within our existing workforce. Disturbing reports continue to show the dwindling percentage of medical students who plan to become primary care physicians… The increased cost of education and a lack of sufficient financial incentives for primary care are a significant factor in this decline. These workforce challenges don't just affect the availability of health care. They also have a significant impact on how the health care delivery system performs…So we need to change incentives to promote emphasis on primary care. We should consider reforming Medicare and Medicaid Graduate Medical Education to more effectively foster broader workforce goals."

Opening Statement of Sen. Chuck Grassley
Hearing: Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future March 12, 2009

"Overhaul of the health care system must not only provide for universal coverage but also for more primary care doctors and nurses to ensure that an insurance card actually gives the holder access to treatment."

Statement by Rep. Henry Waxman
Hearing: Making Health Care Work for American Families: Improving Access to Care March 24, 2009

"We…find that payments are provided to hospitals without accountability for how they are used or without targeting policy objectives consistent with what Medicare's goals are."[1] "Policy makers should also consider ways to use some of the Medicare subsidies for teaching hospitals to promote primary care. Such efforts in medical training and practice may improve our future supply of primary care clinicians and thus increase beneficiary access to them."[2]
"[MedPAC] found that among the small share of beneficiaries looking for a new primary care physician, 30 percent reported some difficulties finding one. Specifically, 12 percent reported "small" problems and 17 percent reported "big" problems."[3]

Medicare Payment Advisory Commission 2008

<u>The Charter of Council on Graduate Medical Education (COGME)</u>
As a reminder, COGME was authorized by Congress in 1986 to provide an ongoing assessment of physician workforce trends, training issues and financing policies, and to recommend appropriate federal and private sector efforts to address identified needs. The legislation calls for COGME to advise and make recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS), the Senate Committee on Health, Education, Labor and Pensions, and the House of Representatives Committee on Energy & Commerce.

The Imperative of Primary Care

COGME is concerned by recent studies showing that the physician training pipeline is contributing to escalating costs that threaten the economic stability of our country. In its 16th report in 2005, COGME recommended a 15% increase in medical school graduates and that "Physicians should be encouraged to select specific specialties with shortages," but refused to be prescriptive about specialty needs. Two recent studies suggest that since the 16th Report, student interest and selection rates for primary care are now 21-24% of graduating students, far below the current 35% share of the physician workforce.[4,5] Surveys of internal medicine residency graduates also suggest that potential primary care physicians are increasingly turning to subspecialty training, hospitalist practice, or other alternative careers.[6] This is further underscored by the results of the 2009 match with regard to family medicine where after a slight uptick in 2008, interest in family medicine among U.S. medical students has returned to its 10-year decline with only 1,083 graduating U.S. medical students -- 89 fewer than last year -- choosing family medicine as their career path. Unfortunately, COGME failed to anticipate how market and medical school influences would further erode interest in specialties shown to be critical to public, personal and economic health.

Likewise, current GME trends are not consistent with a more cost effective primary care-based health care system. Between 2002 and 2006, despite a Medicare GME payment cap, teaching hospitals increased subspecialty training positions by nearly 25% but reduced family medicine training by almost 3%.[3] Since the GME cap was put in place in 1996, primary care internal medicine positions in the annual student Match have fallen by 57%, primary care pediatric positions by 34%, and family medicine by 18%.[7] It is unclear how many of these are being filled outside of the Match and how many have disappeared. While some teaching hospitals maintain a commitment to primary care, to Medicare's goals and to the health of the public, the overall picture suggests that financial concerns have affected the majority of teaching hospitals' decisions about selection of training positions.

Review of Previous COGME Recommendations

The 16th COGME report called for an expansion of undergraduate training positions by15%. Surveys by the Association of American Medical Colleges indicate that allopathic and osteopathic schools are on track to nearly double this mark by 2012.[8] In the 19th COGME report (2007), the Council suggested a need for GME expansion by the same percentage. We recognize now that this failed to account for the fact that GME positions already exceeded allopathic medical school graduates by 30% (In 2007-8, the US graduated about 17,500 allopathic students but had more than 25,000 first year residency positions).[9,10] Despite the already existing excess and Medicare payment cap, first year residency positions grew by nearly 8% between 2002 and 2007.[8] This expansion will accommodate the growth of medical school production; however, because nearly all of this expansion was in subspecialty training, it will reduce primary care production.

The country needs more strategic GME expansion with new incentives for choosing primary care. This is critical to fulfilling Congressman Waxman's and MedPAC's goal of assuring access to primary care. This objective would also support Senator Grassley's goal of reorienting the health care system for improved health outcomes and efficiency.

Current COGME Recommendations

Recommendation 1 of the 19th COGME report calls for aligning GME with future healthcare needs. This is entirely in keeping with MedPAC's recommendation and the current interests of the Senate Finance and HELP committees. The future of healthcare is moving more care, particularly complex care, into the community and even patients' homes. Our current training infrastructure and funding will not prepare physicians for this future. There is a concerted effort to transform primary care practice

into more robust, more complex Medical Homes. We must train the next generation of physicians in this model and GME funding could facilitate this. Medicare's investment in graduate medical education training should be accountable for the health of the public, particularly Medicare beneficiaries, and should move training into new places and models.

Recommendation 2 of the 19th COGME report calls for a broadening of the definition of "training venue". There is currently an imbalance in the locus of training that is not adequately preparing a physician workforce for outpatient care, where most of health care takes place, nor in exposing young physicians to rural and underserved settings. Medicare and Medicaid beneficiaries would benefit from physician training moving out of the hospital into rural and community health centers and physician offices, both directly, in terms of service, but later as physicians exposed to working in these settings decide it is a career option. Training in community, rural and underserved settings has been shown to increase physician choice of working in such settings.[11] The Government Accountability Office has emphasized the intractable problem of physician distribution twice in the last decade.[12] [13] GME funding has become a barrier rather than a facilitator of improving physician distribution and access to care.

Recommendation 3 of the 19th COGME report is to remove regulatory and statutory barriers limiting flexible GME training programs and training venues. Recent regulatory efforts to pay for community-based GME by private practice physicians had the unintended consequence of retrenching training back in hospitals. CMS had the good goal with the "Community Preceptor" regulation of paying for community physician education of trainees. Unfortunately the required payment, or reporting required to avoid it, had the reverse effect of pulling those positions back into hospitals. This new regulation and Medicare's 40 year old model of paying for physician training stand in the way of progress. If Medicare GME funding is retooled, the regulatory process must also be directed by statute, not just report language, to create incentives to accommodate these changes.

Recommendation 4 of the 19th COGME report calls for making accountability for the public's health the driving force for graduate medical education. The nearly $10 billion spent annually on GME can no longer afford to be bent to the needs of hospitals. We appreciate the need to help teaching hospitals with the problems of workforce and financial solvency that GME currently serves, but we cannot afford the byproduct of an overly-specialized and expensive physician workforce. With modification the byproduct of GME funding could be a reshaping of the role of teaching hospitals in meeting the needs of the public. Clearly, 25% growth in subspecialty training when there is no societal imperative for this makes this dependence even more explicit and at odds with societal needs.

COGME's Next Report

COGME is now working on a 20th report that will focus more globally on the alignment of policies along the physician production pipeline to best balance the physician workforce and support health system reform. It will work from the preparation and selection of students for medical school all the way through to payment policies. Our discussions and draft report concepts may be useful to MedPAC and Congressional Committees.

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[1] MedPAC. Public meeting transcript, October 2, 2008; p8. http://medpac.gov/transcripts/1002-1003MedPAC.pdf

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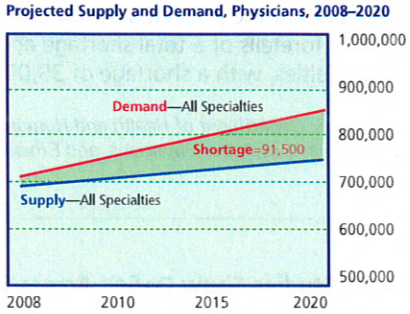
AAMC
Tomorrow's Doctors, Tomorrow's Cures®

Physician Shortages to Worsen Without Increases in Residency Training

The passage of health care reform, while setting in motion long-overdue efforts to insure an additional 32 million Americans, will increase the need for doctors and exacerbate a physician shortage driven by the rapid expansion of the number of Americans over age 65. Increasing graduate medical education by eliminating the 13-year freeze in Medicare's support for training positions is essential to address the projected shortfall.



Unless We Act Now, America Will Face a Shortage of More than 90,000 Doctors in 10 Years

- The U.S. Department of Health and Human Services estimates that the physician supply will increase by only 7 percent in the next 10 years. In some specialties, including urology and thoracic surgery, the overall supply of physicians will actually decrease. At the same time, the Census Bureau projects a 36 percent growth in the number of Americans over age 65, the very segment of the population with the greatest health care needs.
- As a result, by 2020 our nation will face a serious shortage of both primary care and specialist physicians to care for an aging and growing population. According to the AAMC's Center for Workforce Studies, there will be 45,000 too few primary care physicians – and a shortage of 46,000 surgeons and medical specialists – in the next decade.
- Our doctors are getting older, too. Nearly one-third of all physicians will retire in the next decade just as more Americans need care.
- The shortfall in the number of physicians will affect everyone, but the impact will be most severe on vulnerable and underserved populations. These groups include the approximately 20 percent of Americans who live in rural or inner-city locations designated as health professional shortage areas.

Both an Aging U.S. Population and Greater Number of Insured Drives Demand for Physician Care

- Though the number of primary care physicians continues to grow (and has doubled in the last three decades), older patients are sicker and have multiple chronic conditions that require more time and coordination. Team-based approaches, like the "medical home," may help reduce the shortage but will not eliminate it.
- Even with the best prevention possible, as the number of elderly grows and people live longer, so will the number of patients with age-sensitive conditions like cancer (almost 100 times higher in older adults); more oncologists, surgeons, and other specialists will need to be trained to ensure timely access to high-quality services.
- In addition to the 15 million patients who will become eligible for Medicare, 32 million younger Americans will become newly insured as a result of health care reform and thereby intensify the demand for physicians even further.
- Because educating and training physicians takes up to a decade, graduate medical education (residency training) must be expanded now.

To Ensure an Adequate Physician Workforce, the Medicare Freeze on Residency Training Must End

Because of the concern with likely shortages, the number of medical schools is increasing, and there will be an additional 7,000 graduates every year over the next decade. Still, there can be no substantial increase in the number of residency training positions supported by the federal government.

- Medicare's support for physician training has been frozen since 1997. Unless the number of residency training positions expands at the nation's teaching hospitals, the United States will face a declining number of physicians per capita just as the baby boomers swell the Medicare rolls.
- Congress must lift the freeze on Medicare-supported residency positions. Because all physicians must complete three or more years of residency training after they receive an M.D. degree, Medicare must continue paying for its share of training costs by supporting at least a 15 percent increase in GME positions, allowing teaching hospitals to prepare another 4,000 physicians a year to meet the needs of 2020 and beyond.

A Physician Workforce Shortage Loomed Even Before the Passage of Health Care Reform.

An analysis of the projected supply and demand for physicians, conducted by the Health Resources and Services Administration in 2008, foretells of a total shortage across the entire workforce. Particularly evident is the deficit projected in nonprimary care subspecialties, with a shortage of 35,000 surgeons and 27,000 medical specialists by 2020.

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration; Exhibit 51, Baseline FTE Supply Projects of Active Physicians, and Exhibit 52, Baseline Physician Requirements Projections, December 2008.

AAMC Studies Show Deficit Across Specialties

Current analysis by the AAMC not only factors in the expansion of health care insurance as a result of reform, but also the changes in physician retirements and specialty choice, as well. This newer model illustrates the critical shortfall in the number of all physician specialties that care for older adults. Even five years from now – in 2015 – there will be a deficit of 62,900 physicians. Looking out further – to 15 years from now, in 2025 – that shortage is likely to have doubled, with a projected deficit of more than 130,000 physicians across all specialties.

Projected Supply and Demand, Full-time Equivalent Physicians Active in Patient Care Post Health Care Reform, 2008-2025

Year	Physician Supply (All Specialties)	Physician Demand (All Specialties)	Physician Shortage (All Specialties*)	Physician Shortage (Non-Primary Care Specialties)
2008	699,100	706,500	7,400	None
2010	709,700	723,400	13,700	4,700
2015	735,600	798,500	62,900	33,100
2020	759,800	851,300	91,500	46,100
2025	785,400	916,000	130,600	64,800

Source: AAMC Center for Workforce Studies, June 2010 Analysis

**Total includes primary care, surgical, and medical specialties.*

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